INTERIM STUDY COMMITTEE ON MEDICAID OVERSIGHT

Legislative Services Agency
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MEETING MINUTES[1]

Meeting Date:	**October 25, 2000**
Meeting Time:	**10:30 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 233**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**5**

Members Present: **Rep. William Crawford, Chair; Rep. Charlie Brown; Rep. Susan Crosby; Rep. Mary Kay Budak; Rep. Gary Dillon; Rep. Dave Frizzell; Sen. Patricia Miller, Vice-Chair; Sen. Robert Meeks; Sen. Vi Simpson; Sen. Rose Antich; Sen. Samuel Smith, Jr..**

Members Absent: **Sen. Marvin Riegsecker.**

Rep. William Crawford, Chair of the Interim Study Committee on Medicaid Oversight, called the fifth meeting of the Committee to order at 10:45 a.m.

Hoosier Healthwise Surveys

Ms. Sharon Steadman, Director of Managed Care Programs, Office of Medicaid Policy and Planning (OMPP), provided a summary of the surveys of providers and members in the Hoosier Healthwise program. (Mr. Carl Hendrickson of Market Measurement, Inc., originally scheduled to provide this testimony, was unable to attend because of a flight cancellation.)

Ms. Steadman provided the Committee with three documents: (1) Hoosier Healthwise Briefing: Hoosier Healthwise 2000 Primary Medical Provider Satisfaction Survey (Exhibit 1); (2) Hoosier Healthwise Briefing: Hoosier Healthwise 2000 Member Satisfaction Survey (Exhibit 2); and (3) an Executive Summary of the two studies prepared for the Committee (Exhibit 3). The Hoosier Healthwise surveys are conducted annually to assess the attitudes, behaviors, and perceptions of the Hoosier Healthwise program by the participating primary medical providers and

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

members. The surveys are conducted by Market Measurement, Inc., a consulting firm under contract with FSSA.

Ms. Steadman, responding to a question by the Committee, stated that much of the information in the surveys is also available by certain counties and regions of Indiana.

Ms. Steadman also, in response to a question about whether auto-assignment of members was still a problem with the program, stated that it still may be, although many problems that providers encounter are often grouped on the survey as a problem with auto-assignment.

Ms. Steadman stated, in response to a question, that efforts are made to encourage compliance with policies regarding emergency room visitations, including Hoosier Healthwise videos produced for the members and member handbooks provided at the time of enrollment.

Update on the Case-Mix Reimbursement System

Ms. Judith Becherer, Director of Long Term Care, OMPP, provided the Committee with a status report on the case-mix reimbursement system two years after implementation. Ms. Becherer provided a report, Indiana Medicaid Case Mix Reimbursement for Nursing Facilities: A Two-Year Report Card, October 25, 2000 (Exhibit 4). She also provided an Executive Summary of the report (Exhibit 5). The report describes the components of the case-mix system, OMPP's experiences with the system over the last two years, and a summary of the status of a number of issues involving the system.

Ms. Becherer reported that the system was implemented on October 1, 1998. She added that the agreement between the state and the nursing home industry is set to expire at the end of 2000. She stated that the case-mix workgroup has met formally 23 times since implementation of the system. Ms. Becherer stated that some of the accomplishments over the last two years include: successful claims payment upon implementation; establishment of a Workgroup that meets regularly; rate-setting process improvements and elimination of backlogs; extensive provider training and educational audits; establishment of a state-of-the-art MDS ("minimum data set") audit program that providers helped to design; a leveling out of expenditures; completion of an Alzheimer's Disease time study; compilation of a nursing facility resident fact book; collaboration with the Indiana State Department of Health on overlapping issues; improved cost coverage; as well as others. She added that OMPP is seeing evidence of providers accepting patients with higher needs, one of the primary goals of the system.

Responding to a question about the caps imposed on the system that act to prevent extremely low reimbursement of nursing facility costs, Ms. Becherer indicated that the caps have never come into play, and that if anything, new costs have continued to drive reimbursement rates up.

Ms. Becherer's written testimony is provided (Exhibit 6).

Drug Formulary Issue

Rep. Dillon informed the Committee of an issue that he was hearing about from other physicians through his physician practice. He told of the reimbursement rate for a pneumococcal vaccine being lowered below cost. He added that providers received no notification of the changes and the changes could potentially have some impact on the number of children receiving immunizations. He stated that he has been talking with Ms. Kathy Gifford, OMPP, and Mr. Mike McKinney, Managed Health Services, and he believes that the problem may be resolved. Ms. Gifford indicated that she was looking into the situation.

Consideration of Proposed Legislation

The following bill drafts were considered and approved by the Committee.

HEA 1130 (2000) - Medicaid and Other Health Payments. This bill requires that payment for emergency services provided to certain individuals in a hospital's emergency department for the evaluation or stabilization of an emergency medical condition must be equal to the current Medicaid fee for service reimbursement rates for emergency services. This bill also requires OMPP to base adjustments to payment rates for certain providers that are reimbursed through the resource based relative value scale (RBRVS) on relative value units, factoring in particular cost indices and conversion factors. It also requires OMPP to update these payment rates at least once every two years.

The bill limits payments that a court may order to be made from a county general fund to facilities for the comfort and care provided to certain mentally ill individuals. The bill also requires OMPP to make additional payments to certain providers during state fiscal year 2001 that increase state expenditures by not less than $2,000,000. The bill also reestablishes the Select Joint Committee on Medicaid Oversight. FSSA is required by the bill to submit proposals regarding certain Medicaid waivers to the Select Joint Committee for review before submitting the proposals to the federal Health Care Financing Administration (HCFA).

The motion to recommend an override of the Governor's veto was properly moved and seconded. The motion passed unanimously by a vote of 11 in favor to zero against. (See Exhibit 7.)

PD 3590 - Disputed Medicaid Hospital Claims. This bill requires that a Medicaid claim submitted for payment by a Lake County disproportionate share hospital be treated as a disputed claim, for purposes of arbitration, under certain circumstances.

The motion to recommend the bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of eight in favor to three against. (See Exhibit 8.) Members indicated that further clarification will need to be made after the bill is introduced.

PD 3576 - Directing of Medicaid Patients to Certain Hospitals. This bill removes the December 31, 2000, expiration date of a provision that: (1) prohibits a Medicaid managed care contractor from providing incentives or mandates to primary medical providers to direct certain Medicaid recipients to contracted hospitals other than a hospital in a city where the recipient resides; and (2) requires certain Medicaid hospitals to comply with eligibility verification and medical management programs negotiated under the hospital's most recent contract or agreement with the Medicaid managed care contractor.

The motion to recommend the bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of nine in favor to one against. (See Exhibit 9.)

PD 3577 - High Tech Home Health Services and Medicaid. This bill defines "high technology home health services" as home health services provided to an individual whose medical needs require high resource utilization. The bill requires OMPP to establish certain payment rates for high technology home health services and to increase these rates annually by the increase in the hospital wage index published by the federal Health Care Financing Administration.

The following changes to the original draft were approved by consent.

Page 1, line 12, between "following" and "payment" insert "maximum."
Page 1, line 18, delete "increase" and insert "review."
Page 1, line 19, delete "by the increase in the hospital wage index published" and insert "."
Page 1, delete line 20.

The motion to recommend the amended bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of nine in favor to one against. The digest of the recommended draft will be changed to reflect the changes approved by the Committee. (See Exhibit 10 for the original draft.)

PD 3471 - Health Center Cost Based Reimbursement. This bill extends for two years a provision that: (1) adds services provided by certain federally defined community health centers to the services that are provided under Medicaid; (2) requires that each community health center continue to receive its total reasonable cost reimbursement rate for providing care to recipients of Medicaid; and (3) requires rural health clinics to be reimbursed under a cost-based methodology.

The motion to recommend the bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of nine in favor to zero against. (See Exhibit 11.)

PD 3472 - Medicaid Payment for Emergency Room Services. This bill extends for two years a statute requiring that, under the Medicaid Primary Care Case Management Program (PCCM), physician services provided to a program enrollee in a hospital emergency department must be at a rate of 100% of rates payable under the Medicaid fee structure, if the service is authorized by the enrollee's primary medical provider.

The motion to recommend the bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of nine in favor to zero against. (See Exhibit 12.)

PD 3300 - Select Joint Commission on Medicaid Oversight. This bill establishes the Select Joint Commission on Medicaid Oversight. The bill also provides for the appointment of Commission members and establishes meeting procedures. The bill provides that the Commission operates under the policies of the Legislative Council, except that the Commission may meet at any time during the calendar year and is not required to file an annual report.

The motion to recommend the bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of nine in favor to zero against. (See Exhibit 13.) Members indicated that this bill would not be needed if the Governor's veto of HEA 1130 (2000) is overridden.

PD 3589 - Medicaid Drug Formularies. This bill defines "therapeutic classification." The bill also provides that a drug formulary adopted by the Medicaid program or a Medicaid managed care organization (MCO) must provide for at least two therapeutically equivalent drugs within each therapeutic classification on the formulary. The bill provides that the Medicaid program or a Medicaid MCO may require prior approval of a drug only to restrict access to single source drugs that are subject to clinical abuse or misuse. The bill also provides criteria for the Drug Utilization Review (DUR) Board to consider in determining whether to approve a Medicaid MCO's proposal to remove or restrict a single source drug. The bill also provides that a Medicaid MCO may remove or restrict a single source drug only under certain conditions. It also requires the DUR Board to review the criteria used by an MCO in determining whether a drug is subject to clinical abuse or misuse.

The following changes to the original draft were approved by consent.

Page 2, line 18, reset in roman "alternative."
Page 2, line 19, delete "therapeutically equivalent."
Page 3, line 33, reset in roman "alternative."
Page 3, line 34, delete "therapeutically equivalent."
Page 3, line 41, delete "review the criteria used by the" and insert "**make a determination that**

the prior approval meets the requirements of subsection (l)."
Page 3, delete lines 42 through 43.
Page 5, line 12, delete "Except as provided in."
Page 5, line 13, delete "subsection (g), if" and insert "If."
Page 5, delete lines 17 through 20.
Page 5, line 21, delete "(h)" and insert "**(g)**."

The motion to recommend the amended bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of eight in favor to one against. The digest of the recommended draft will be changed to reflect the changes approved by the Committee. (See Exhibit 14 for the original draft.)

Other preliminary drafts provided to the Committee were either not considered or were withdrawn from consideration. These included PD 3468 (Exhibit 15), PD 3470 (Exhibit 16), PD 3585 (Exhibit 17), PD 3473 (Exhibit 18), PD 3474 (Exhibit 19), PD 3478 (Exhibit 20), PD 3587 (Exhibit 21), PD 3496 (Exhibit 22), and PD 3564 (Exhibit 23).

Consideration of the Final Report

Consent was granted for staff to make changes to the last paragraph on page five of the draft of the final report to incorporate additional information regarding the testimony received about the dispute between Gary Methodist Hospital and Managed Health Services.

The motion to approve the final report was properly moved and seconded. The motion passed by a vote of eight in favor to zero against.

Additional information distributed to Committee members at the meeting included the following: (1) a memo from staff regarding additional information on wage pass-throughs for nursing facilities (Exhibit 24); (2) an updated report from the Indiana Association of Area Agencies on Aging regarding waiting lists for services by county as of October 25, 2000 (Exhibit 25); and (3) a status report on the negotiations between Gary Methodist Hospital and Managed Health Services as of October 25, 2000 (Exhibit 26).

There being no further business to consider, the meeting was adjourned at 1:10 p.m.